STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29C0001065	A. BUILDING _____ B. WING _____	04/24/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE ENDOSCOPY	7150 SMOKE RANCH ROAD, SUITE 150 LAS VEGAS, NV 89128

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Q 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare validation survey conducted at your facility on April 22 and 23, 2008. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Twelve patient records and 3 employee files were reviewed. The facility failed to maintain condition level compliance with the following Conditions of Coverage: 42 CFR 416.41 - Governing Body and Management 42 CFR 416.42 - Surgical Services 42 CFR 416. 44 - Environment The following regulatory deficiencies were identified:	Q 000		
Q 003	416.41 GOVERNING BODY AND MANAGEMENT The ambulatory surgical center must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the center's total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these	Q 003		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 003	Continued From page 1 services are provided in a safe and effective manner. This CONDITION is not met as evidenced by: The center failed to ensure the governing body implemented and monitored policies governing the center's total operation and failed to ensure the contracted outside service for anesthesiology was provided in a safe and effective manner (Q003); failed to ensure surgical procedures were performed in a safe manner by qualified physicians who had been granted clinical privileges by the governing body of the ASC (ambulatory surgery center) in accordance with approved policies and procedures of the ASC (Q005); and failed to ensure the ASC had a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients (Q010). The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care. Based on interview, credentialing file review and policy review, the center failed to ensure the contracted outside service for anesthesiology was implemented and monitored in accordance with the center's policy for 1 of 2 physicians (#2). Interview On 4/22/08 in the early afternoon, the credentialing files for physicians at the center were reviewed and the Director of Nursing revealed Physician #2 was "undergoing credentialing" and the process was incomplete. Policy & Procedure Review	Q 003		

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Q 003	Continued From page 2 1. The center policy numbered Section 10, Subsection 1, and titled " Temporary Privileges and Inactive Status," adopted on 8/1/06 and last approved on 2/27/07, on page 37, documented the following: a. Subsection 1: " the (center) administrator, after conference with the Medical Director, shall have the authority to grant temporary privileges to a physician who is not a member of the Medical Staff ...the Medical Director shall give an authoritative opinion as to the competence and ethical standing of the physician who desires temporary privileges...temporary privileges will be granted for a period of 90 days and will allow the physician the ability to attend to no more than four patients during this time period..." 2. The facility policy titled "Medical Staff Rules and Regulations," numbered 1.8, contained the following statements and forms: a. Medical Staff, 2., page 47, "...only members who have submitted proper credentials and have been duly appointed to membership on the active Medical Staff with privileges granted or temporarily granted may treat patients ..." b. Recommendation and Authorization of Physician Privileges, page 50, "I, Recommend approval of privileges for Dr._____to practice at (center), and "The Governing Body of (center) hereby grants privileges for Dr. _____to practice at (center), signed by the Medical Director and Governing Body Chairperson, dated 2/27/07. The form was not completed with Physician #2's name granting	Q 003		

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Q 003	Continued From page 3 privileges. c. Physician Temporary Privilege Assignment, page 51, was not completed, signed, or dated by the applicant, medical director, and the administrator. d. Delineation of Privileges Authorization, page 52, was not completed, signed, or dated by the administrator or governing body chairperson. Credentialing File Review 1. The credentialing file for Physician #2 did not contain the center's completed forms including: Recommendation and Authorization of Physician Privileges, Physician Temporary Privilege Assignment, or the Delineation of Privileges Authorization. 2. The credentialing file for Physician #2 did not contain documentation of a completed background check.	Q 003		
Q 005	416.42 SURGICAL SERVICES Surgical procedures must be performed in a safe manner by qualified physicians who have been granted clinical privileges by the governing body of the ambulatory surgical center in accordance with approved policies and procedures of the center. This CONDITION is not met as evidenced by: The center failed to ensure surgical procedures were performed by physicians with clinical privileges granted by the governing body and in accordance with approved policies and procedures of the facility.(Q005)	Q 005		

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Q 005	Continued From page 4 The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated care to the patients. Based on interview, credential file review, and policy review the center failed to grant clinical privileges in accordance with center approved policies and procedures for 1 of 2 physicians (#2). Interview On 4/22/08 in the early afternoon, the Director of Nursing (DON) revealed the credentialing process was not complete for physician #2. The DON indicated physician #2 had performed four procedures at the center. Policy Review 1. The center policy outlined in "Section 10, subsection 1" and titled "Temporary Privileges and Inactive Status" adopted on 8/1/06 and last approved on 2/27/08, was not followed for physician #2. a."Temporary Privileges and Inactive Status" on page 37 stated the following: "...temporary privileges will be granted for a period of 90 days and will allow the physician the ability to attend to no more than four patients during this time period..." b. Physician #2 attended to 4 patients on the following dates: 2/7/08, 4/18/08, 4/22/08 for 2 patients, verified by patient record review. 2. The center form titled "Recommendation and Authorization of Physician Privileges," page 50, was not completed for physician #2.	Q 005		

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Q 005	Continued From page 5 3. The center form titled "Physician Temporary Privilege Assignment," page 51, was not completed for physician #2. 4. The center form titled "Delineation of Privileges Authorization," page 52, was not completed for physician #2. Credentialing File Review 1. The credentialing file for physician #2 did not contain documentation of a background check or completed credentialing process. 2. The credentialing file did not contain documentation of "Temporary Privilege Assessment" for physician #2. Physician #2 attended to 4 patients from 2/7/08 - 4/22/08 and per center policy cannot "attend to no more than four patients during this time."	Q 005		
Q 010	416.44 ENVIRONMENT The ambulatory surgical center must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is not met as evidenced by: The center failed to ensure a sanitary environment was maintained based on the improper storage of sanitized tubing used for the cleaning and sanitizing of endoscopes, the improper storage of soiled linen in the recovery room area (Q11), and failing to have an infection control policy that correctly provided for the proper disposal of blood and infectious fluids (Q14). The cumulative effect of these systemic practices	Q 010		

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Q 010	Continued From page 6 resulted in the failure of the center to deliver statutory mandated care to the patients.	Q 010		
Q 011	416.44(a) PHYSICAL ENVIRONMENT The ambulatory surgical center must provide a functional and sanitary environment for the provision of surgical services. This STANDARD is not met as evidenced by: Based on observation and staff interview, the center failed to ensure a sanitary environment was maintained for the provision of surgical services. Findings include: 1. A tour of the center was made with the center's Director of Nursing (DON) on 4/22/08 at 9:00 A.M. During this tour observation was made of the surgical equipment cleaning area, located between procedure rooms #1 and #2. Clear plastic tubing used for the flushing of endoscopes during the sanitation process was observed to be hanging over the water faucet and into the sink. The cleaning area was observed again on 4/22/08 at 12:20 P.M. During this observation the DON stated the tubing should not have been stored hanging over and into the sink since the sink was considered to be contaminated. The DON stated the tubing should have been hung inside the bottom door of the endoscope cleaning machine, which was considered to be a clean area. 2. During a tour of the center on 4/22/08 at 9:00 A.M. observation was made of the recovery area for patients. The linen hamper in the recovery area was observed to have the lid of the hamper open and was observed to be overflowing with	Q 011		

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Q 011	Continued From page 7 soiled linen. This prevented the lid from closing and containing the soiled linen. Observation was made of the recovery area on 4/23/08 at 11:45 A.M. The hamper was again observed to have the lid opened and be overflowing with soiled linen.	Q 011		
Q 014	416.44(a)(3) ELEMENT of STANDARD PHYSICAL ENVIRONMENT The ambulatory surgical center must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. This ELEMENT is not met as evidenced by: Based on record review and staff interview, the center failed to ensure there was an adequate infection control policy related to the disposal of infectious waste from blood or infectious spills using a solidifier. Findings include: 1. A review of the policy and procedure manual was completed on 4/23/08. The section of the manual titled " Subject: Blood-borne Pathogens/Standard Precautions, Policy Number: 6.2 " was reviewed. On page 205 of this section the policy stated under the heading "Spill clean-Up Procedure", " Blood or potentially infectious spills shall be cleaned up immediately by: a. Donning Gloves, b. Wipe up spill with absorbent material (use of a fluid solidifier is optional), c. Place spill clean-up materials in plastic bags. If fluid solidifier was used, regular trash is adequate, d. Following cleanup, apply a disinfectant. " An interview regarding this policy was conducted with the center's Director of Nursing (DON) on	Q 014		

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Q 014	Continued From page 8 4/22/08 at 4:15 P.M. The DON stated the policy was incorrect related to using the regular trash to dispose of blood or potentially infectious spills that were cleaned up using a solidifier. The DON stated it should direct the staff to dispose of blood and infectious waste in red bags for hazardous waste disposal rather than disposing of these items in the regular trash.	Q 014		
Q 030	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure there was a policy in effect that provided for an effective way to destroy and dispose of expired medications. Findings include: A review of the center's Policy and Procedure Manual was made on 4/22/08. Under the section of the manual titled, " Subject: Medication Administration, Storage, and Disposal, Policy Number 4.5 " a sub section on page 154 was titled, " Disposal Procedure ". Under the subsection item three (3) states, "Any expired medications will be disposed of in the sharps containers. Every month, a delegated member of the nursing staff shall check the medication stock for expired medications, disposing expired meds appropriately." In an interview with the Director of Nursing (DON) on 4/22/08 at 4:15 P.M. the DON confirmed the policy for disposal of medications in the sharps container. The DON confirmed the procedure for	Q 030		

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Q 030	Continued From page 9 disposing of the medications in the sharps container did not destroy the medication and make them unusable.	Q 030		